SMITH CHIROPRACTIC & SPORTS REHAB

1487 NE DAWN RD. BREMERTON WA 98311 PH: 360-373-8899

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

Emergency Contact:_____ Relationship: _____ Contact Number:_____

Medical Doctor: _____ Last Visit: _____ How Did You Hear About Us:_____

Authorization and Release:

*I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. **Initials**:_____

*I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. **Initials:**_____

*I understand that if my insurance carrier does not pay for services provided by Smith Chiropractic & Sports Rehab, these fees become my financial responsibility. **Initials:**_____

*By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from the provider(s), its staff, Its contractors, collections agents, and others at any numbers I provide or that are later acquired for me. These parties may use this Information to contact me by live agent, voice mail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication, including email at any email address I provide, for any purpose. **Initials:**_____

Late Charges:

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In care of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. **Initials:**_____

Other Fees:

We realize emergencies come up, but if you need to cancel an appointment for any reason, we request that you make every attempt to give us 24 hours' notice. By giving adequate notice of cancellation you allow us to help others more quickly. If you do not contact our office prior to your appointment you will be billed a missed appointment for of $55. For any returned checks there will be a charge of $35. **Initials:**_____

Consent to Treat a Minor:

As parent or legal guardian, I have the authority to authorize and do hereby grant the Chiropractors at Smith Chiropractic & Sports Rehab to administer chiropractic care as they deem necessary to my son/daughter/ward. **Initials:**_____

Signature:_____ **Date:**_____

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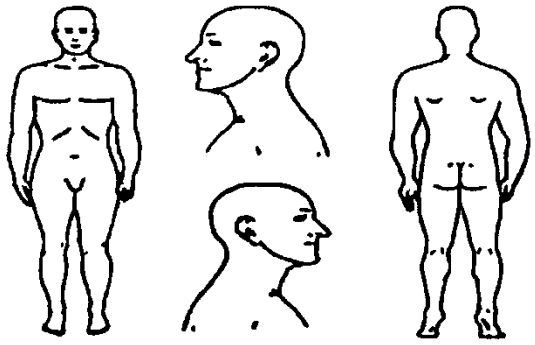
Chief Complaint

What is *PLEASE CIRCLE YOUR AREAS OF COMPLAINT & LABEL 1-2* *Height*_____ *Weight*_____



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

_____

How is your condition changing? □ BETTER □ WORSE □ NOT CHANGING

Do you feel the sensation travels anywhere else? _____

How often do you experience your symptoms?

□ Constantly (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (0-25%)

Describe what your symptoms feel like: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

Right Now:_____ On Average:_____ At Worst:_____

Do your symptoms affect your daily activities?_____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **SECOND** complaint? _____When and how did it begin? _____

_____

How is your condition changing? □ BETTER □ WORSE □ NOT CHANGING

Do you feel the sensation travels anywhere else? _____

How often do you experience your symptoms?

□ Constantly (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (0-25%)

Describe what your symptoms feel like: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

Right Now:_____ On Average:_____ At Worst:_____

Do your symptoms affect your daily activities?_____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

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Patient History

Please mark if you have experienced any of these issues.

General
_____Weight loss/gain
_____Allergies
_____Bleeding problem
_____Anemia
_____Diabetes
_____Cancer
_____Thyroid disease
_____Alcoholism
_____Drug abuse
_____HIV risk factor

Eye, Ear Nose & Throat
_____Poor vision
_____Loss of vision
_____Pain in eyes
_____Deafness/difficulty hearing
_____Nosebleeds
_____Sinus problems
_____Dental problems
_____Hoarseness
_____Tonsillitis

Cardiovascular
_____Irregular heart beat
_____Pain over heart
_____High blood pressure
_____Previous heart trouble
_____Myocardial infarction
_____Ankle Swelling
_____Varicose Veins
_____Rheumatic fever
_____Stroke

Skin
_____Itching
_____Bruises easily
_____Changes in mole(s)
_____Skin Cancer

Health Habits
_____Smoking- current
_____Smoking- past
_____Drinking
_____Recreational drug use

Exercise
_____None
_____1-2x/week
_____3-5x/week
_____6-7x/week

Respiratory
_____Difficulty breathing
_____Chronic cough
_____Spitting phlegm
_____Spitting blood
_____Wheezing/Asthma
_____Pneumonia
_____Tuberculosis

Genitourinary
_____Frequent urination
_____Painful urination
_____Blood in Urine
_____Kidney Disease
_____Urinary infection
_____Inability to control urine
_____Difficulty starting urine flow
Get up _____times/night to urinate
_____Breast lump or pain
_____Venereal Disease
_____Sexual difficulty

Neurologic
_____Weakness
_____Twitching
_____Tremors
_____Headache
_____Dizziness/Vertigo
_____Epilepsy
_____Numbness/tingling
_____Arm/leg pain
_____Mental Disorder
_____Partial or complete paralysis

Other
_____Tropical infection
_____Parasitic Infection

Men Only
_____Testicular Pain
_____Prostate Problems

Women Only
_____Live births
_____Miscarriage
_____Painful Period
_____Excessive flow
_____Irregular cycle
_____Hot flashes
Date of last period:_____
Date of last PAP: _____
Date of last mammogram:_____

Gastrointestinal
_____Poor appetite
_____Poor digestion
_____Difficulty swallowing
_____Vomiting blood
_____Pain over abdomen
_____Ulcer
_____Bloody stool
_____Liver problems
_____Gallbladder problems
_____Jaundice
_____Hernia
_____Loss of bowel control
_____Diarrhea
_____Constipation
_____Hemorrhoids
_____Appendicitis

Musculoskeletal
_____Neck Stiffness/pain
_____Pain between shoulders
_____Low back pain
_____Swollen joints
_____Painful joints
_____Muscle aches/soreness
_____Spinal curvature
_____Arthritis
_____Osteoporosis
_____Slipped/herniated disc

Family History
_____Diabetes
_____Thyroid Disease
_____Kidneys disease
_____High Blood Pressure
_____Heart Disease
_____Cancer
_____Epilepsy
_____Stroke
_____Gout
_____Allergies
_____Blood disease
_____Other

Allergies: _____
_____
_____

Vitamins: _____
_____
_____

Nutrition: _____
_____
_____

Surgeries:_____
Medications:_____
_____

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Informed Consent

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Exercise and nutritional counseling may also be used.

Although spinal manipulation/adjustment is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Active Release Technique and **IASTM** technique may occasionally leave slight bruising and tenderness. **(Instrument Assisted Soft Tissue Mobilization)**

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform our providers if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormally is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

A thorough health history and tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Signature_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For further details, please ask to see the NOTICE OF PRIVACY PRACTICES.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice, or one has been made available to me.

_____ _____

Signature of patient or representative Date

_____ _____

Print patient name Patient Birth Date